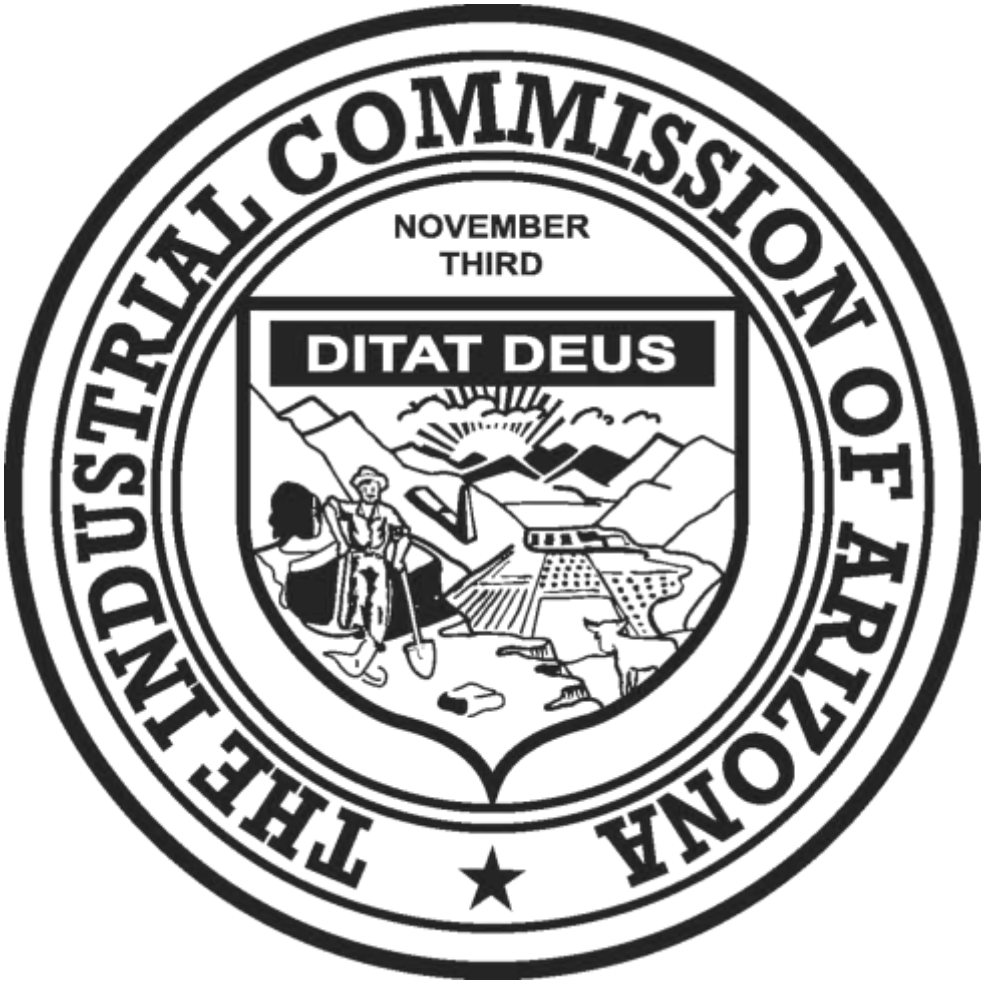
Unscheduled Permanent Disability Awards (Loss of Earning Capacity)

Presented By:

Bonnie Holly,

Special Fund Manager



Agenda

- Scheduled vs Unscheduled
- What is a Loss of Earning Capacity (LEC)
- How to issue a unscheduled closure
- Loss of Earning Capacity Awards
- Apportionment
- Annual Report of Income

Scheduled v Unscheduled

Scheduled Injuries
Pursuant to A.R.S. §23-1044(B)

Those types of injuries include:

- Fingers, hand, arm
- Toes, foot, leg
- Eye
- Ear/ears
- Loss of one or more teeth or permanent facial disfigurement about the head or face

(Or both facial and teeth within one claim based on opinion of the Commission)

Unscheduled injuries

Pursuant to A.R.S. §23-1044(C)

Are injuries NOT listed under A.R.S. §23-1044(B).

These types of injuries could include:

- Head injuries & Psychological conditions
- Spine (Neck/Back)
- Shoulder(s)
- Hip(s)
- Internal
- Bilateral wrists/arms or knees/legs
- 2 separate injuries, each resulting in a scheduled injury. The 2nd injury would convert to the unscheduled category - ARS-23-1065(B)

Unscheduled Injuries

Injuries to the head, spine, hips or shoulders are *unscheduled* injuries on their own.

Knee, foot, elbow (scheduled) injuries *do not* become unscheduled injuries on their own.

What is a Loss of Earning Capacity Award

Unscheduled Permanent Impairment

Loss of Earning Capacity

Injury to an UNSCHEDULED part of body results in a whole person impairment rating

Instead of based on a “schedule” of months, it based on ability to work.

- May have a Loss or No Loss
- Loss
  - Partial Loss
    - Unable to return to date of injury work but can work in other capacities
    - Result in a lifetime award of 55% of the difference between AMW & earnings after MMI (life or until further award by ICA)
  - Total Loss
    - Unable to work in any capacity
    - Result in a lifetime award of 66 2/3% of the AMW (life or until further award by ICA)

Who issues a loss of earning capacity award?

The Industrial Commission Claims Division

When Applicant is Stationary aka MMI

Closing Packet:

Issue 104 #6 & 8,

107 AND

supporting medical records

And….

☐ 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.

☐ 7. Injury resulted in no permanent disability.

☐ 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.

#1A – If the injured worker is discharged with a general unscheduled disability rating

#1B – If the injured worker is discharged with a scheduled disability as a result of current injury and has a history of prior industrially related scheduled disability

#1C – If the injured worker has been discharged with a general unscheduled disability and has a history of a non-industrial medical condition or disability.

#1D – For apportionment requested for injuries prior to January 1, 1986

NOTICE OF PERMANENT DISABILITY AND REQUEST FOR DETERMINATION OF BENEFITS

Carrier or Self-Insured Name and Address

Authorized Third Party Administrator Name and Address

Claimant's Name and Address

ICA Claim No. _____

Soc. Sec. No. _____

Carrier Claim No. _____

Employer _____

Address _____

Date Injured _____

You are hereby notified of a permanent disability, pursuant to the provisions of A.R.S. 23-1047. The Industrial Commission of Arizona is hereby requested to examine this claim to determine the amount of further compensation, if any, to which claimant may be entitled. Copies of all pertinent reports necessary to make such a determination are herewith forwarded to the Commission.

The type of disability is:

1. Unscheduled permanent partial disability.
   - ☐ a. Pursuant to A.R.S. 23-1044-C
   - ☐ b. Pursuant to A.R.S. 23-1065-B (Submit proof of prior scheduled award and termination date)
   - ☐ c. Pursuant to A.R.S. 23-1065-C (Substantiating medical and employer verification attached)
   - ☐ d. Pursuant to pre-1-1-86 apportionment statutes (Specify which section)
2. ☐ Permanent facial disfigurement or loss of teeth (Specify which category)
3. ☐ Fatal with non-enumerated dependents.
4. ☐ Fatal where dependents are only partially dependent upon deceased's earnings for support at time of injury.
5. ☐ Non-enumerated permanent total disability.
6. ☐ Advance payments voluntarily made will be credited against permanent compensation awarded. Advance payments will be as follows:

Please Provide Details:

Mailed On: _____ By: _____

(Authorized Representative) Tel. #: _____

Copy to: Industrial Commission of Arizona

So what exactly is a position paper?

It is an Earning Capacity recommendation for the injured worker

Can be completed by a LMC expert, or even by the adjuster.

2020 Claims Adjusting Manual

What to Include in a Position Paper

Date and description of injury

Body part/s

Date of birth / age

Educational background

Employment at date of injury/ employment history

Location of residence at date of injury, location where employment was being performed at date of injury, and current location of residence

Physical work restrictions related to industrial injury

Criminal history

If apportionment is being requested – does the w/c injury and preexisting condition hinder return to work

2020 Claims Adjusting Manual

Factors to consider in the Position Paper

- Voc Rehab
  - What job were they trained for and what earnings are possible.
- Return to work for the DOI Employer?
  - Documentation of job that the applicant is working.
- Return to work for a different Employer?
  - Documentation of earnings/wages.

2020 Claims Adjusting Manual

Unscheduled Closure Checklist

___Average Monthly Wage Established

___Form 104, #6 with date compliant with R118, and #8

___Form 107 appropriately marked

___Supporting Medical Records

___Apportionment requested? Include supporting documents

___Position Paper to include the following :

- Birth date/Age of injured worker
- Location of residence at date of injury; location of where claimant performed work at date of injury; current location of residence
- Educational Background/Criminal History
- Employment History
- Previous Injuries or non -industrial Medical Conditions
- Physical Work Restrictions related to industrial injury
- Rate of pay and number of hours per week for post injury employment
- Current Working Status
  - Insured employer or different employer

(See “What to Include in A Position Paper” for full details)

The LEC Questionnaire is sometimes mailed to the claimant when the Notice of Permanent Disability and Request for Determination of Benefits Form 107 is received and more information is required

LOSS OF EARNING CAPACITY QUESTIONNAIRE

Date:
ICA Case No:
Date of Injury:

Date of Birth:

Telephone No: _____

Please complete this questionnaire in ink, using the back of this form if necessary. Attach any documentation you want the Commission to consider in determining your earning capacity, including medical limitations. Absent a response from you within 30 days our decision will be made based on information contained in the file. (Note: If your work status changes after you have returned this form please let us know). RETURN THIS FORM TO: THE INDUSTRIAL COMMISSION OF ARIZONA P.O. BOX 19070,. PHOENIX AZ 85005-9070

GENERAL INFORMATION:

1. If you are represented by an attorney, please give name: _____
2. Are you right or left handed? _____
3. Describe any physical disabilities prior to date of injury: _____
4. Do you have a valid driver's license? _____
5. Education: Completed years of high school: _____ Completed years of college: _____
   Other: _____
6. Previous work experience: _____

EMPLOYMENT INFORMATION ON DATE OF INJURY:

1. Name of employer: _____ Phone: _____
   Address: _____
   Occupation: _____ Job Duties: _____
   Hourly rate: $ _____ Monthly rate: $ _____ O.T. rate: $ _____ Number of hours worked per week: _____
   O.T. hours worked per week: _____ If you worked less than 40 hours , why? _____
2. Is same job currently available to you? _____ If no, list on reverse side places you have applied and/or worked since the injury. (Name of employers and occupations)

IF YOU ARE CURRENTLY WORKING PLEASE FILL IN BELOW:

1. Name of employer: _____ Phone: _____
   Address: _____
   Occupation: _____ Job Duties: _____
   Hourly rate: $ _____ Monthly rate: $ _____ O.T. rate: $ _____ May we contact your employer to verify your Earnings? _____ If not, furnish verification of earnings. Number of hours currently working per week: _____ O.T.: _____
   If working less than 40 hours, why? _____
   Date of Hire: _____

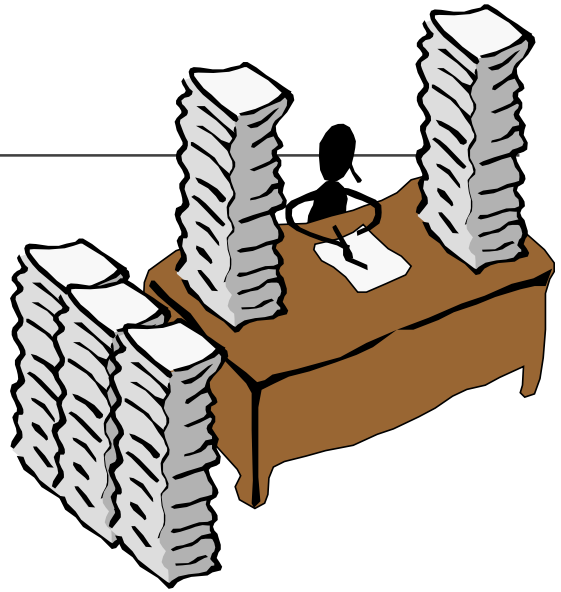
Date: _____ Signature: _____

A.R.S.§23-1048 (A)
Reasonable accommodations; earning capacity determination

Wages payable for a modified job position shall be included in the determination of any temporary partial or permanent partial earning capacity, notwithstanding that the modified job is *not* available in the open competitive labor market.

LEC Examples

No Loss of Earning Capacity Sample (A.R.S. § 23-1044(C)



DATE OF INJURY:	03-16-2018
AMW:	$4,625.92
TYPE OF INJURY:	Back
PERMANENT IMPAIRMENT:	10% whole person
OCCUPATION:	Maintenance Supervisor

After conservative medical treatment, injured worker was released from medical care with no physical work restrictions.

Upon review of this, ICA found that injured worker sustained no loss in earning capacity.

No Loss Findings And Award for Unscheduled Permanent Partial Disability

BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, AZ 85005

JOE SMITH
Applicant

vs.

ANY JOB
Defendant Employer

ANY INSURANCE CO
Defendant Insurance Carrier

ICA CASE NO: 20015-258631
CARRIER CLAIM NO: WC-2015
DATE OF INJURY: 9/13/16

FINDINGS AND AWARD FOR UNSCHEDULED PERMANENT PARTIAL DISABILITY

Applicant sustained an industrial injury on September 13, 2016. A Notice was issued closing the claim effective May 24, 2017. On June 16, 2017 defendant insurance carrier issued a Notice of Permanent Disability and Request for Determination of Benefits pursuant to A.R.S. §23-1047 and indicating applicant sustained an unscheduled permanent partial impairment resulting in a general physical functional disability. The Industrial Commission of Arizona having fully considered the file, records and all matters herein and hereunto appertaining now enters Findings and Award as follows:

FINDINGS

1. As a result of the September 13, 2016 industrial injury, applicant underwent medical treatment and benefits were terminated effective May 24, 2017. At the time of injury applicant was employed as a Custodian for defendant employer. Applicant is presently 58 years of age. The relevant labor market is Flagstaff. Applicant's average monthly wage is established at $1819.86.

2. The applicant has returned to full work and/or has been released to full work by Dr. Feelbetter, report dated May 24, 2017 thus, it is found that applicant has sustained no loss of earning capacity. In determining applicant has no loss of earning capacity as a result of the injury, the Industrial Commission has given full consideration to each of the matters set forth in A.R.S. §23-1044(D), and full consideration to all other facts and circumstances pertaining to this case.

JOE SMITH
20015-258631
9/13/16

No Loss - Award

AWARD

IT IS ORDERED that no further compensation be awarded for the reason that the applicant has suffered no reduction in earning capacity by reason of the injury on September 13, 2016 or the general physical functional disability resulting therefrom.

IT IS FURTHER ORDERED that the Industrial Commission retains the jurisdiction of all compensation cases for the purpose of altering, amending or rescinding its findings and award on the motion of either the applicant, the insurer, or the employer, (1) upon showing a change in the physical condition of the applicant subsequent to the findings and award arising from the injury resulting in the reduction or increase in the earning capacity, (2) upon showing of a reduction in the earning capacity of the applicant arising from the injury where there is no change in his physical condition subsequent to the findings and award; (3) upon a showing the applicant's earnings have increased subsequent to the findings and award.

IT IS FURTHER ORDERED if you do not agree with this award and wish a hearing on the matter, your written Request for Hearing must be received in either office of the Industrial Commission of Arizona within NINETY (90) DAYS after the mailing of this award, pursuant to A.R.S. §23-941 and §23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS AWARD IS FINAL.

THE INDUSTRIAL COMMISSION OF ARIZONA

BY _____
Special Assistant

Signature authorized pursuant to Commission Resol
A.R.S. §23-108.03.

Dated at Phoenix, Arizona this

_____ day of _____, 20

No Loss – injured worker information

NOTICE TO APPLICANT

Information in your file indicates that your injury is not affecting your earning ability at this time. Under the provisions of the Workers' Compensation Act, we have entered our final award accordingly.

We wish to assure you that our award does not necessarily mean that your case is permanently closed. The law protects you by giving you the right of reopening for further benefits should your injury cause you difficulty in the future, or if your earning ability is lessened by reason of your injury.

If you find that it is necessary for you to reopen your case, forms are available for such application, and we will be glad to assist you. Evidence substantiating either new and additional disability or a decrease in earning capacity should accompany the request.

If you have any questions about your award, we will be glad to explain anything that seems unclear.

When does an LEC Award Become Final?

The injured worker or the insurance carrier / payer has ninety (90) days to protest an LEC Award and request a Hearing.

No Loss with Vocational Rehabilitation Bonus Sample

A.R.S. § 23-1065(B)(1)

PRIOR DATE OF INJURY:	10-11-2006 5% permanent impairment of the left upper extremity
CURRENT DATE OF INJURY:	02-24-2018 10% permanent impairment of the right lower extremity
AMW:	$4,226.80
OCCUPATION:	Pipefitter

Injured worker was released from medical care with no physical work restrictions; therefore, ICA found that he sustained no loss of earning capacity.

However pursuant to A.R.S. § 23-1065(B)(1) injured worker was found to be entitled to a vocational rehabilitation bonus, in the amount calculated pursuant to A.R.S. § 23-1044(B), to be paid in a **lump sum** which is a credit against any permanent compensation benefits awarded in any subsequent proceeding.

REHAB BONUS: 10% x 50 months (A.R.S. § 23-1044{B}{15})= 5 months
$4,226.80 x 50% (A.R.S. § 23-1044{21})= $2,113.40
$2,113.40 x 5 = $10,567.00

Loss of Earning Capacity Sample (A.R.S. § 23-1044(C))

DATE OF INJURY:	04-15-2018
AMW:	$4625.92
TYPE OF INJURY:	Right shoulder
PERMANENT IMPAIRMENT:	15% whole person
OCCUPATION:	Fire Fighter

Injured worker was unable to return to his duties as a fire fighter; therefore, ICA found that he could perform the duties of a customer service representative which was readily available in the open competitive labor market. On the date of injury this position was found to have paid $15.86 per hour or $2,748.86 per month, which results in a 40.58% reduction in earning capacity entitling the injured worker to the monthly sum of $1,032.38.

$ 4,625.92
- 2,748.86
$ 1,877.06 = 40.58% LEC
x .55 = (A.R.S. § 23-1044{C})
$ 1,032.38 = monthly LEC entitlement

What is the period of time LEC Awards are paid?

Loss of Earning Capacity Awards are lifetime benefits unless a claimant's earning capacity is rearranged under A.R.S. § 23-1044 (F) or the claimant enters into a settlement agreement with the carrier for their monthly entitlement.

What are rolled back wages?

To determine earning capacity, real or hypothetical wages *must* be rolled back to the date of injury value. The process to roll back wages uses the current CPI and CPI for the date of injury. This allows for an "apples-to-apples" comparison of earning capacity.

Apportionment!

WHY IS APPORTIONMENT WORTH ALL THE TROUBLE?

Apportionment

- Known to many as the "Second Injury Fund"
- When approved, LEC is paid by Carrier & 50% is reimbursed by Special Fund

Apportionment

MOST COMMON TYPES OF APPORTIONMENT

1065(B) – 2ND SCHEDULED MAKING THE CLAIM UNSCHEDULED

1044(E) –'ROTH' CREDITS FOR PRIOR SCHEDULED CLAIM

Things to Remember about Apportionment pursuant to A.R.S. §23-1065(B) and credits pursuant to A.R.S. §23-1044(E)

- Issue the closing 107 checking off box 1B
- Submit the prior scheduled 104, 106 and medical documentation
- Prior records can be obtained at the Industrial Commission by using our Community at azica.gov
- Calculate the “scheduled” amount for apportionment using 75% of the average monthly wage unless there are other factors involved
- Credits are spread out over the injured worker’s lifetime
- You can use perm awards from other states.
- The carrier makes the LEC payments and requests reimbursement from the Special Fund every year

Second scheduled injury, unable to return to date of injury job. This would qualify for apportionment under ARS 23-1065(B)(2)

Loss of Earning Capacity with Apportionment (A.R.S.§23-1065(B)(2) AND CREDIT A.R.S. § 23-1044(E))

PRIOR DATE OF INJURY: 01-03-2009
35% permanent impairment of the left lower extremity
CURRENT DATE OF INJURY: 03-10-2018
20% permanent impairment of the right major upper extremity

AMW: $4,112.00
OCCUPATION: Carpenter

LEC: The ICA found that the injured worker was unable to return to the duties of Carpenter; therefore, ICA found that the injured worker could perform the duties of a driver which was readily available in the open competitive labor market. On the date of injury this position was found to have paid $10.52 per hour or $1,823.33 per month which would result in a 55.66% reduction in earning capacity entitling the injured worker to the monthly sum of $1,258.77.

$4,112.00
1,823.33
$2,288.67 = 55.66% LEC
X .55 = (A.R.S.§23-1044{C})
$1,258.77 = monthly LEC entitlement

APPORTIONMENT: 20% x 60 months (A.R.S.§23-1044{B}{13}) = 12 months
$4,112.00 x 75% *(A.R.S.§23-1044{B}{21})= $3,084.00
$3,084.00 x 12 months = $37,008.00 value of scheduled award

(*)Because the applicant is unable to return to the date of injury employment due to the industrial injury, the amount the carrier must pay first before being eligible for reimbursement under 23-1065(B) is calculated using a 75% factor. (If the injured worker is unable to return to the applicant's usual and customary occupation due to a combination of other factors not related to the industrial injury, the value of the scheduled award is to be paid at 50% of the average monthly wage.

Insurance carrier is to pay the injured worker $1,258.77 per month until the sum of $37,008.00 has been fully paid, 29.4 months after which the monthly entitlement of $1,258.77 will be shared on an equal basis between the insurance carrier and the ICA Special Fund.

Loss of Earning Capacity with Apportionment & Credit
A.R.S. § 23-1065(B)(2) and CREDIT (A.R.S. § 23-1044(E))

CREDIT: Applicant's prior injury of 1-3-09 was terminated as of 10-03-2009 in which the applicant was paid a scheduled award of $33,300.00 per Notice of Permanent Disability or Death Benefits issued on 10-03-2009. Applicant's life expectancy, in accordance with the Life Tables contained in The United States Life Tables, 2003, National Vital Statistics Reports, Vol. 54, number 14, April 19, 2006, revised March 28, 2007, Table 1, Life Table for the total population: United States, 2003, was 34.0 years or 408 months based on the applicant's age of 46 years at time of termination. *See R.G. Roth Construction Co. v. Indus. Comm'n*, 126 Ariz. 147, 613 P.2d 307 (App. 1980).

$33,300.00 ÷ 408 = $81.62 credit per month for a period of 408 months

$ 4,112.00
- 1,823.33
$ 2,288.67 = 55.66% LEC
x .55
$ 1,258.77 = monthly LEC entitlement
- 81.62 = credit per month for a period of 408 months
$ 1,177.15 = monthly entitlement for a period of 408 months, thereafter $1,258.77

Total Loss of Earning Capacity

A.R.S. § 23-1045

DATE OF INJURY:	04-15-2018
AMW:	$4,625.92
TYPE OF INJURY:	Neck
PERMANENT IMPAIRMENT:	24% whole person
OCCUPATION:	Manager

Injured worker was unable to return to any form of gainful employment due to the industrial injury; therefore, ICA determined that the applicant was totally disabled.

$4,625.92
X 66.67% (A.R.S. § 23-1045)
$3,084.10 = monthly LEC entitlement

Note: Injured worker would be entitled to 65% of the average monthly wage if the date of injury is prior to 8-8-73.

You will probably never need this, but it's in the book

Apportionment – Second Scheduled Injury Sustained Between 07-31-1980 and 12-30-1985 (A.R.S. § 23-1065(B))

PRIOR DATE OF INJURY:	04-09-1977
SCHEDULED PERMANENT IMPAIRMENT:	4% of the left ring finger
CURRENT DATE OF INJURY:	09-15-1985
SCHEDULED PERMANENT IMPAIRMENT:	25% of the right wrist
AMW:	$1,325.00
OCCUPATION:	Truck Driver

Injured worker was unable to return to duty as a truck driver; therefore, ICA found that the applicant could perform the duties of a telephone solicitor which was readily available in the open and competitive labor market. On the date of injury the position of telephone solicitor was found to have paid $3.35 per hour or $580.62 per month which results in a 56.18% reduction in earning capacity entitling the applicant to the monthly sum of $409.41.

$ 1,325.00
580.62
$ 744.38 = 56.18% LEC
X .55 = (A.R.S. § 23-1044{C})
$ 409.41 = monthly LEC entitlement

The insurance carrier pays the first 50% reduction in earning capacity plus ½ of anything over 50%:

Benefits are to be apportioned pursuant to A.R.S. § 23-1065(B) (2) as follows:

56.18% (reduction in earning capacity)
50.00% (insurance carrier's responsibility for 1st 50%)
$ 6.18% ÷ 2 = 3.09%

50.00% + 3.09% = 53.09% (portion of reduction in earning capacity insurance carrier is responsible for)
3.09% (portion of reduction in earning capacity ICA Special Fund is responsible for)

The following formula is used:
53.09% ÷ 56.18% = 94.50% x $409.41 = $ 386.89 - Carrier responsibility
3.09% ÷ 56.18% = 5.50% x $409.41 = $ 22.52 - ICA Special Fund's responsibility
$ 409.41 - Total Award

Apportionment

1065(C) – PRE-EXISTING NON-INDUSTRIALLY RELATED MEDICAL CONDITION

Apportionment per ARS 23-1065(C)

Three Things to Remember…….

1. The non-industrial pre-existing impairment must be 10% or greater per the AMA Guidelines comes from the listing of qualified conditions in the statute (i.e., epilepsy, diabetes, arthritis, etc. full listing under 23-1065C (3))

2. Impairment presents a hindrance or obstacle to employment

3. Employer had knowledge of permanent impairment at the time of hire, or the employee continued in employment after the employer acquired such knowledge, but prior to the date of injury.

Annual Report of Income

Injured worker responsibility to report annual earnings

The Insurance Carrier has the right to know what earnings the claimant reported each year. The Worker's Annual Report of Income Form (110A) is filed on the ***anniversary date*** of the claimant's LEC Award.

The 110A

Sent by carrier to injured workers receiving permanent compensation benefits one month prior to anniversary date of the award.

WORKER'S ANNUAL REPORT OF INCOME

Return to: Carrier or Self-Insured Employer Address

Claimant's Name and Address

Date Mailed: _____

ICA Claim No.: _____

Soc. Sec. No.: _____

SSN not required if correct ICA claim number is provided

Carrier Claim No. _____

Employer: _____

Date of Injury: _____

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Failure to submit an annual report within 30 days of the date of this notice shall result in the suspension of benefits by the carrier or self-insured employer.

	MO.	DAY	YEAR		MO.	DAY	YEAR
Period				Through			

Name and Address of Employer *(Include Self Employment)*	Period Worked From	Through	Total Wages and other Earnings	Describe Work
			$	
			$	
			$	
			$	
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $ _____

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date _____

Email address: _____ Current Residence _____

Phone: _____

Address to which mail should besent::

Street _____

City _____ State _____ Zip Code _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 04—110-A (Rev 6/2015)

The 110B

NOTICE OF INTENT TO SUSPEND

Return to: Carrier or Self-Insured Employer Address

ime and Address

Date Mailed: _____

ICA Claim No.: _____

Soc. Sec. No.: _____

SSN not required if correct ICA claim number is provided

Carrier Claim No. _____

Employer: _____

Date of Injury: _____

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Payment of further benefits will be suspended unless information called for in the space provided below is received in this office within THIRTY (30) DAYS from this date.

	MO.	DAY	YEAR		MO.	DAY	YEAR
Period				Through			

Name and Address of Employer *(Include Self Employment)*	Period Worked From	Period Worked Through	Total Wages and other Earnings	Describe Work
			$	
			$	
			$	
			$	
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $ _____

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date _____

Email address:_____ Current Residence _____

Phone:_____ _____

Address to which mail should be sent::

Street _____

City _____ State _____ Zip Code _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

The 105

NOTICE OF SUSPENSION OF BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date Injured _____

All compensation and medical payment benefits suspended by the above-named insurance carrier effective DATE because claimant:

☐ 1. Left the State of Arizona without the written approval of the Industrial Commission of Arizona.

☐ 2. Refused to submit to obstructed a medical examination.

☐ 3. Failed to submit a required annual report of income.

☐ All compensation benefits suspended by the above-named insurance carrier effective _____ because claimant is incarcerated. Medical benefits will continue. Any court-ordered child support payments are to continue.

Mailed On: _____ By: _____

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: _____

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NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

WORKERS ANNUAL REPORT OF INCOME

Return to: Carrier or Self-Insured Employer Address

ABC Insurance Company
1234 Giant Cactus Avenue
Phoenix, AZ 85000

Date Mailed: **00/00/16**
ICA Claim No.: **20015-999994**
Soc. Sec. No.: **123-45-6789**

SSN not required if correct ICA claim number is provided

Carrier Claim No. **246810**
Employer: **Bob's Cool Stuff**
Date of Injury: **9/1/04**

Claimant's Name and Address

Joan Jackson
4321 W Parker
Phoenix AZ 85000

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Payment of further benefits will be suspended unless information called for in the space provided below is received in this office within THIRTY (30) DAYS from this date.

AMW $2400.00 **EARNING CAPACITY $1733.20** **LEC ENTITLEMENT $366.74**

MO DAY YEAR	MO DAY YEAR
Period 5/1/2015	**Through 5/1/2016**

Name and Address of Employer *(Include Self Employment)*	Period Worked From	Period Worked Through	Total Wages and other Earnings	Describe Work
Green Things 2400 Wilson Ave Phx, AZ	**5/15**	**5/16**	**$31,838.32**	**Plant Plucker**
			$	
$31,838.32 ÷ 12 = $2653.19			$	
			$	
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE **$31,838.32**

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date _____

Email address: _____ Current Residence _____

Phone: _____ _____

Address to which mail should be sent::

Street _____

City _____ State _____ Zip Code _____

When reported annual earnings are greater than the earnings used to calculate monthly entitlement you may want to file a Request for Rearrangement.

WORKERS ANNUAL REPORT OF INCOME

Return to: Carrier or Self-Insured Employer Address

ABC Insurance Company
1234 Giant Cactus Avenue
Phoenix, AZ 85000

Date Mailed: **00/00/16**
ICA Claim No.: **20015-999994**
Soc. Sec. No.: **123-45-6789**

SSN not required if correct ICA claim number is provided

Claimant's Name and Address

Joan Jackson
4321 W Parker
Phoenix AZ 85000

Carrier Claim No.: **245810**
Employer: **Bob's Cool Stuff**
Date of Injury: **9/1/04**

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Payment of further benefits will be suspended unless information called for in the space provided below is received in this office within THIRTY (30) DAYS from this date.

AMW $2400.00 **EARNING CAPACITY $1733.20** **LEC ENTITLEMENT $366.74**

MO. DAY YEAR	MO. DAY YEAR
Period 5/1/2015	**Through 5/1/2016**

Name and Address of Employer *(Include Self Employment)*	Period Worked From	Period Worked Through	Total Wages and other Earnings	Describe Work
Green Things 2400 Wilson Ave Phx, AZ	**5/15**	**5/16**	**$31,838.32**	**Plant Plucker**
			$	
$31,838.32 ÷ 12 = $2653.19 (roll back this wage to 2004) = $2094.73				
Recommended LEC would be $167.90 http://www.bls.gov/data/inflation_calculator.htm				
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE **$31,838.32**

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date _____

Email address: _____ Current Residence _____

Phone: _____

Address to which mail should be sent::

Street _____

Petition for Rearrangement

Criteria for rearrangement
A.R.S. §23-1044(F)

- A change in the physical condition of the employee due to the industrial injury resulting in the reduced or increased earning capacity.
- A reduction in the earning capacity of the employee where there is no change in the employee's physical condition, after the findings and award.
- The employee's earning capacity has increased after the findings and award.
- *Reminder: Roll back the earnings to DOI to ensure change in earnings.

INDUSTRIAL COMMISSION OF ARIZONA

IMPORTANT: This completed form must be filed at an Industrial Commission of Arizona (ICA) office. (See addresses below.)

PETITION FOR REARRANGEMENT OR READJUSTMENT OF COMPENSATION

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the ICA claims and hearing process are available at the ICA offices and through the ICA web-site located at: www.ica.state.az.us

_____ Injured Worker

vs.

_____ Defendant Employer

_____ Defendant Insurance Carrier

Social Security No. * _____

Date of Injury: _____

ICA Claim No.: _____

Ins. Carrier Claim No.: _____

Injured Worker ☐ Carrier ☐ Requests rearrangement or readjustment of compensation for the following reasons:

_____

_____

1. State below all employment of injured worker within the past two years:

NAME & ADDRESS OF EMPLOYER INCLUDING SELF-EMPLOYMENT	PERIOD WORKED FROM (MO. DAY YR.)	PERIOD WORKED THROUGH (MO. DAY YR.)	TYPE OF WORK	TOTAL WAGES EARNED	REASON FOR TERMINATION
A.			✓		
B.					
C.					

2. List all other income or compensation received within the last two years:

RECEIVED FROM / ADDRESS	TOTAL AMOUNT
A.	$
B.	$

3. Has the injured worker had any other accident, injury or illness since this claim was closed? YES ☐ NO ☐ If yes, explain:

_____

4. The following physicians have examined or treated the injured worker within the past two years for the conditions listed:

DOCTOR'S NAME	ADDRESS	CONDITION AND DATE OF TREATMENT
A.		
B.		

I have read this Petition for Rearrangement or Readjustment of Compensation and the information contained is true and correct to the best of my knowledge.

_____ Signature of petitioner or petitioner's authorized representative is REQUIRED.

_____ Date

_____ Address

_____ Telephone No.

_____ City _____ State _____ Zip

Phoenix: Industrial Commission of Arizona
Mailing address: P.O. Box 19070
Phoenix, Arizona 85005-9070

Street Address: 800 W. Washington Street
Phoenix, Arizona 85007-2922

Tucson Office: Industrial Commission of Arizona
2675 E. Broadway
Tucson, Arizona 85716-5342

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

Thank you for Joining Us
Q&A